The POLICY Project

Reproductive Health
Case Study

GHANA

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The Futures Group International

in collaboration with

Research Triangle Institute (RTI)

The Centre for Development and Population Activities (CEDPA)

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Executive Summary

The International Conference on Population and Development (ICPD) held in Cairo in 1994 intensified worldwide focus on reproductive health policies and programs. Many countries have worked to adopt the recommendations from the ICPD *Programme of Action* and to shift their population policies and programs from an emphasis on achieving demographic targets for reduced population growth to improving the reproductive health of their population. The POLICY Project has conducted eight country case studies to assess each nation's process and progress in moving toward a reproductive health focus. The purpose of the country reports is to describe the policy environment for reproductive health and the role of the 1994 ICPD in sparking and shaping policies and programs in reproductive health. The field work for the Ghana Reproductive Health Case Study was carried out from December 1 to 12, 1997. Interviews were conducted with 44 persons involved in reproductive health programs in Accra, Dodowa, and Amanase.

Ghana's family planning movement began in the 1960s. Working together, the public and private sectors developed the 1969 population policy, *Population Planning for National Progress and Prosperity*. In 1970, the government established the National Family Planning Program (NFPP). Lessons learned from implementing the NFPP facilitated subsequent policy formulation and implementation, including the 1992 creation of the National Population Council (NPC), the successor to the NFPP, and the revised 1994 *National Population Policy*. Both the 1996 *National Reproductive Health Service Policy and Standards*, which serve as an operational policy for the Ministry of Health (MOH) and the nongovernmental and private sectors, and the draft *Adolescent Reproductive Health Policy* address reproductive health concerns.

Ghana enjoys a long history of broad participation in population and reproductive health policymaking. Nongovernmental organizations (NGOs) and the private sector are involved in policy formulation and implementation at the national, regional, and district levels.

The success of Ghana's population and reproductive health policies and programs depends to a large extent on the decentralization of the Ghanaian government. District assemblies have been given financial resources and planning authority and are charged with facilitating government development initiatives and providing social services for residents of their communities. Sector ministries, including the MOH and the NPC, are also decentralizing. They will work with the district assemblies to ensure that planning addresses sector issues and that the various sectors receive adequate resources.

Knowledge of the concept of reproductive health among population policymakers and program managers is high; however, that knowledge has not filtered down to community-level health workers. Many public and private sector providers do not know the term "reproductive health" and do not offer reproductive health services. Even so, they demonstrate considerable knowledge of specific reproductive health elements, such as family planning and HIV/AIDS.

Despite widespread support for population and reproductive health issues in Ghana, government officials, and community and religious leaders are not deeply committed. While these officials and leaders are not actively opposed to reproductive health, they are not particularly proactive in advancing the reproductive health agenda. Respondents believed the lack of support is due to a lack of knowledge and awareness more than to explicit objections to population and reproductive health issues.

Ghana was already focusing on reproductive health issues long before the ICPD; since Cairo, however, the concept of reproductive health has undergone greater refinement and found broader application.

Reproductive health services are available through the public, nongovernmental, and private sectors. Most NGOs are involved in information and education with regard to reproductive health, but only a few provide services. Nonetheless, these few are instrumental in serving underserved and disadvantaged populations. Public and private midwives are being trained and equipped to provide postabortion care and emergency reproductive health services. Respondents from all sectors agreed that adolescent, HIV/AIDS, and family planning services are priority issues in reproductive health.

The integrated approach to reproductive health service provision has developed over time in Ghana. Program managers decided early on that maternal health and child health services should be offered jointly. At present, full reproductive health service integration does not exist within the MOH. Linkages exist only between selected components; generally, maternal and child health and family planning are linked to sexually transmitted diseases, HIV/AIDS, and postabortion care services. NGOs are trying to promote service integration, but with limited success.

Ghana faces several challenges in addressing sociocultural barriers to reproductive health service utilization, including increasing the depth of awareness and political support for reproductive health issues, especially HIV/AIDS; strengthening the service delivery infrastructure and availability of trained personnel; making decentralization effective; and ensuring the continued participation of NGOs and the private sector.

Abbreviations

AIDS	acquired immune deficiency syndrome
CBD	community-based distribution
DHS	Demographic and Health Survey
DHMT	District Health Management Team
FGM	female genital mutilation
FP	family planning
FPHP	Family Planning and Health Project
GMA	Ghana Medical Association
GRMA	Ghana Registered Midwives Association
GSMF	Ghana Social Marketing Foundation
HIV	human immuno-deficiency virus
ICPD	International Conference on Population and Development
IEC	information, education, and communication
IMR	infant mortality rate
IPPF	International Planned Parenthood Federation
MCH	maternal and child health
MMR	maternal mortality ratio
MOF	Ministry of Finance and Economic Planning
MOH	Ministry of Health
NACP	National AIDS Control Programme
NCWD	National Council on Women and Development
NDPC	National Development Planning Commission
NFPP	National Family Planning Program
NGO	nongovernmental organization
NPC	National Population Council
PIP	Population Impact Project
PGA	Parliamentarians for Global Action
PPAG	Planned Parenthood Association of Ghana
RTI	reproductive tract infection
STD	sexually transmitted disease
TAC	Technical Advisory Committee
TBA	traditional birth attendant
TCC	Technical Coordinating Council
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development

1. Introduction

The International Conference on Population and Development (ICPD) held in Cairo in 1994 intensified worldwide focus on reproductive health policies and programs. Many countries have worked to adopt the recommendations from the ICPD *Programme of Action* and to shift their population policies and programs from an emphasis on achieving demographic targets for reduced population growth to improving the reproductive health of their population.

The POLICY Project has conducted eight country case studies to assess each nation's process and progress in moving toward a reproductive health focus. Case studies were conducted in Bangladesh, Ghana, India, Jamaica, Jordan, Nepal, Peru, and Senegal. The purpose of the country reports is to describe the policy environment for reproductive health and the role of the 1994 ICPD in sparking and shaping policies and programs in reproductive health. A report summarizing experiences across the eight countries and examining trends in the development and implementation of reproductive health policies and programs accompanies the country reports.

Based on epidemiological significance and the recommendations from the ICPD *Programme of Action*, reproductive health care in the case studies is defined as including the following elements:

- prevention of unintended pregnancy through **family planning services**;
- provision of **safe pregnancy services** to improve maternal morbidity and mortality, including services to improve perinatal and neonatal mortality;
- provision of **postabortion care services** and abortion services as permitted by law;
- prevention and treatment of reproductive tract infections (**RTIs**) and sexually transmitted diseases (**STDs**) and **HIV/AIDS**;
- provision of **reproductive services to adolescents**;
- improvement of **maternal and infant nutrition**, including promotion of **breastfeeding programs**;
- screening and management of **specific gynecological problems** such as **reproductive tract cancers,** including **breast cancer**, and **infertility**; and
- addressing of **social problems** such as prevention and management of harmful practices, including **female genital mutilation** and **gender-based violence**.

The country case studies were conducted through in-depth interviews with individuals in the areas of population and reproductive health. Respondents included representatives from government ministries, parliaments, academic institutions, NGOs, women's groups, the private sector, donor agencies, and health care staff. Not all groups were represented in each country case study. The interview guide included the definition of and priorities for reproductive health; how reproductive health policies have been developed; the committees or structures responsible for reproductive health policy development, including the level of participation from various groups; support for and opposition to reproductive health; the role of the private sector and NGOs; how services are implemented; national and donor funding for reproductive health; and remaining challenges to implementing reproductive health policies and programs. Interviews focused on the sections of the interview guide where the respondent had knowledge and expertise. POLICY staff or consultants served as interviewers for the case studies.

Interviews were carried out in Ghana from December 1 to 12, 1997, with 44 persons from 18 different organizations as well as with individual consultants and private practitioners. Additional information was

gathered in Washington, D.C., in discussions with several representatives of technical assistance organizations based in the United States.

2. Background

Ghana is a West African country bounded on the west by Togo, on the east by Côte d'Ivoire, on the north by Burkina Faso, and on the south by the Atlantic Ocean. The country's three vegetation zones consist of a coastal savannah zone characterized by shrubs and mangrove swamps and a forest belt that gradually becomes a dry savannah in the northern half of the country (Nabila et al., 1997). Administratively, Ghana is divided into 10 regions and 110 districts.

After gaining independence in 1957, Ghana experienced nearly 35 years of political and economic instability marked by alternating military and civilian rule. In 1992, Flight Lieutenant Jerry Rawlings, who had acted as head of state since 1981, bowed to internal and international demands to end the ban on political activities and associations (McCaskie, 1993). Multiparty elections were held in late 1992, at which time Rawlings won the presidency. The Fourth Republic of Ghana was established as a constitutional democracy in January 1993.

Ghana's economy is largely agricultural, employing three-fifths of the country's labor force. Other areas of economic activity include a small mining and light industry sector and a growing informal sector of small businesses, artisans, and technicians (Nabila et al., 1997). After several decades of economic deterioration, the average annual growth in the gross domestic product climbed to 4.3 percent for 1990–1994 (World Bank, 1996b). Per capita gross national product totaled US$430 (World Bank, 1996a). In 1995, the government of Ghana issued its Vision 2020, with a long-term objective of making Ghana a middle-income country by the year 2020 through an export-led growth strategy (NDPC, 1995). In 1994, 51 percent of the labor force were women (World Bank, 1996b). In 1995, the illiteracy rate for women was 47 percent compared to 24 percent for men (World Bank, 1996b).

Ghana's population totaled 16.6 million in 1994 with an annual population growth rate of 2.8 to 3 percent (GSS and MI, 1994). Ghana has experienced rapid urbanization and urban growth; in 1994, 36 percent of the population lived in urban areas. Rural to urban migration, in particular, is a challenge to existing facilities and services in urban areas. With respect to international migration, the last 25 years have seen Ghana shift from a country of immigration to one of emigration (GSS and MI, 1994).

The largest share of Ghana's population is Christian (64 percent); 18 percent practice traditional religion or are animists; 14 percent are Muslim, and 4 percent adhere to other religions. Muslims are located predominantly in the northern parts of the country, with smaller concentrations in larger cities in the south (Nabila et al., 1997).

Ghana is a pronatalist society, such that a woman's fertility has great influence on her status (Awusabo-Asare et al., 1993). Surveys from the 1970s through 1988 indicated a total fertility rate of more than 6 children per woman, with a rate of 6.4 in 1988. By 1993, total fertility fell to 5.5 (Nabila et al., 1997). Marriage is early and universal. In 1993, the mean age at first marriage for girls was 19; approximately 28 percent of currently married women are in polygamous unions (GSS and MI, 1994). Knowledge of contraception is high: 91 percent of men and women know at least one method (GSS and MI, 1994). Nevertheless, contraceptive use remains low; only 20 percent of currently married women and 34 percent of currently married men use any method of contraception (10 percent modern methods).

Adolescent reproductive health receives much attention in Ghana. Nearly one-half (48 percent) of the population is under age 15, and 20 percent is age 15 to 19. Teenage pregnancy, in particular, is a prominent social and health issue and clearly related to early initiation of sexual activity and nonuse of contraception. In 1993, the median age at first intercourse for girls was 17. Over 50 percent of females age 15 to 19 have had some sexual experience, one-half of whom are not married. For boys, the mean age at first sexual experience is 16. In 1993, 22 percent of women had become mothers before age 20. Sixty-nine percent of women age 15 to 19 who have given birth reported that their last birth was unplanned or unwanted (Nabila et al., 1997). Contraceptive use among adolescents is markedly low, leaving teenagers unprotected from unwanted pregnancies. Adolescents age 15 to 19 have the lowest rate of contraceptive use (11 percent) of any age group.

The infant mortality rate in 1993 was 56 and the under-five child mortality rate was 119. Children whose mothers received modern medical care during pregnancy and/or delivery experienced lower levels of infant mortality. For prenatal care, 86 percent of mothers received care from medically trained personnel in 1993. For delivery, 42 percent of births occurred in a health facility, and 59 percent of deliveries were supervised. Only 2 percent of children under three months and 5 percent of children age two to three months are exclusively breastfed. At two to three months, 45 percent of infants are breastfed and receive some form of food supplementation (GSS and MI, 1994).

The maternal mortality ratio for 1994 was 742 (World Bank, 1996b). Abortion is illegal in Ghana except in cases of rape, incest, or health risk to the mother. Abortion complications were the single highest contributor to maternal mortality (Otsea et al., 1997) and accounted for 9 to13 percent of maternal deaths in 1990–1991. Of total gynecological admissions, 16 percent were due to abortion-related complications (Center for Reproductive Law and Policy and International Federation of Women Lawyers, 1997). Many adolescents resort to unsafe abortions; in fact, the main cause of maternal mortality among adolescents is septicemia, arising from septic abortion (Nabila et al., 1997).

Knowledge of STDs is high among the population: 97 percent for males and 94 percent for females, with gonorrhea the most commonly recognized STD. The proportion of the general population reporting ever having suffered an STD varies between males and females. According to one study, 28.5 percent of surveyed males reported an STD while only 4.6 percent of females reported an infection. These figures are likely an understatement, reflecting the stigma that Ghana attaches to STDs (Nabila et al., 1997). Further, those who are asymptomatic may not recognize their condition.

Knowledge of HIV/AIDS and its means of transmission is also widespread—94.7 percent for women and 96 percent for men (GSS and MI, 1994)—although people do not fully understand the disease or its implications (Nabila et al., 1997). The first cases of AIDS were detected in Ghana in 1986. As of December 1996, 20,859 cases had been reported to the Ministry of Health. It is estimated that the officially reported cases represent less than 50 percent of all cases in country. As of 1996, about 500,000 people were infected with HIV. Sentinel surveillance findings indicate an HIV prevalence rate of 1 to 3 percent among pregnant women and 4 percent in the general population (NACP, 1997).

Because it largely affects those in their reproductive and productive years, AIDS has dire social and economic consequences for individuals and families. Almost 90 percent of cases occur in adults ages 20 to 49 (NACP, 1995), although young people between ages 15 to 24 appear to have the highest infection rate (Nabila et al., 1997). In addition, more women than men are infected with AIDS. In 1992, women accounted for 71 percent of AIDS cases (NCWD, 1995). By the year 2000, it is estimated that Ghana will be home to 160,000 AIDS orphans (NACP, 1995).

Other reproductive health issues include female genital mutilation (FGM) and violence against women. It is estimated that 30 percent of women and girls (2.3 million females) have undergone FGM in Ghana. FGM practices are most common in Muslim communities in the northern regions of Ghana and among Muslim migrant communities in the urban south. A 1994 law prohibiting FGM makes the practice a second-degree felony punishable by imprisonment. In yet another objectionable tradition, more than 4,500 girls and women are subject to female religious bondage prescribed by the *trokosi* system. Laws against slavery, forced labor, and rape as embodied in both the national Constitution and criminal code implicitly prohibit the custom. Outlawing FGM and religious bondage has had little effect (Center for Reproductive Law and Policy and International Federation of Women Lawyers, 1997).

The criminal laws against wife beating, rape, and other offenses against women, lack special measures to combat violence against women (NCWD, 1995). Rape is a first-degree felony; marital rape is not criminalized in Ghana (Center for Reproductive Law and Policy and International Federation of Women Lawyers, 1997). Violence against women is related to their low status in general. Men are the primary decision makers in all areas of daily life, and women are traditionally regarded for their ability to produce many children.

3. Policy Formulation

A. Evolution of Policies from Family Planning to Reproductive Health

The history of Ghana's family planning movement, particularly the debates over and difficulties with the first family planning program, sets the context for the nation's current structure of policymaking and implementation. Respondents noted that lessons learned from the National Family Planning Program (NFPP) facilitated subsequent policy formulation and implementation, including the establishment of the National Population Council (NPC), the successor to the NFPP.

The Family Planning Movement and the 1969 Population Policy

Ghana has witnessed two major phases of population activities: early public and private activities that focused on family planning programs in the 1960s to 1970s, followed by a hiatus until the mid-1980s when renewed efforts brought about an expanded population program.

In the early 1960s, the Christian Council of Ghana initiated the family planning movement by promoting Christian family living and addressing the problems of too many (or sometimes too few) children in families. In 1961, the council opened a family planning center in Accra (Nabila, 1986). In 1962–1963, the government of Ghana sponsored the United Nations resolution on "Population Growth and Economic Development," and, in 1967, Ghana became the first sub-Saharan African country to sign the World Leaders' Declaration on Population (Ampem, 1991; Rawlings, 1985). In another 1967 milestone, a group of physicians and demographers led the founding of the Planned Parenthood Association of Ghana (PPAG), an International Planned Parenthood Federation (IPPF) affiliate. The goal of the PPAG was to decrease infant and child mortality and abortion; at the time, the PPAG offered limited family planning services.

In 1968, the Ministry of Finance established the Manpower Board, which, along with the PPAG and the Christian Council, initiated the 1969 population policy, entitled *Population Planning for National Progress and Prosperity.* The 1969 policy aimed to integrate demographic and development goals by

introducing measures to reduce unemployment, regulate the rate of migration to cities, reduce the high rates of morbidity and mortality, and target malnutrition (Rawlings, 1985). Population policy leaders in Ghana viewed the 1974 World Conference on Population in Bucharest as an affirmation of the 1969 population policy (Kwafo, 1987). Respondents expressed pride in the policy, which was at that time only the third population policy in the world.

To implement the policy in 1970, the Manpower Board established the Ghana NFPP to offer services on a larger scale than the Christian Council and PPAG could sustain. Respondents recalled that they were optimistic about the NFPP's potential for implementing broad-based population programs and delivering family planning services. The NFPP did not, however, fulfill its potential and ran into problems soon after its establishment. To begin, it was instituted as a coordinating body for population activities and located under the Ministry of Finance and Economic Development (MOF). Moreover, the NFPP Plan of Implementation and Operation did not clarify the specific roles of key ministries. As a result, disputes ensued, especially with the main service delivery ministry, the Ministry of Health (MOH). A university respondent commented, "There was a lack of coordination. The NFPP was not enough. Many thought it was a loose thing." Nonetheless, respondents recounted that NFPP staff members were enthusiastic and that the program was well funded. In response to the lack of clearly defined ministry roles, the NFPP stepped beyond its coordination role and began to offer family planning services; it even opened its own clinics. One government respondent said that the NFPP "infuriated and alienated other agencies."

Not surprisingly, the NFPP encountered problems that adversely affected its implementation activities: personality conflicts; poor institutional coordination, especially between the MOH and the NFPP; an ineffective family planning service delivery system; and competition among donor organizations working through different ministries (NPC, 1994; MOF, 1991; Kwafo, 1987). In addition, political and economic instability compromised implementation (Benneh et al., 1989). One university respondent explained that the series of coups in the 1970s and early 1980s focused the attention of government officials on "more pressing issues other than population." One representative from a U.S. technical assistance organization said, "There was an interruption in governance with the 1972 coup. The government didn't believe in population and development."

> "The major problem [in the 1970s] was that aspects of the government gave tacit support [for the NFPP], but there was no political will. People in the bureaucracy were afraid to talk of family planning. Ministers did not see the need for family planning and population planning... There were so many other issues to talk about. Population was not that important."
>
> University respondent

Rethinking Population Policies and Programs

Launched with commendable objectives, the NFPP raised awareness of family planning, especially in urban areas; however, in terms of overall achievement, the program made only "modest gains" (Ampem, 1991; Benneh, 1987). NFPP components other than family planning, particularly health, education, and the role of women, were not considered priorities (MOF, 1991; Nabila, 1986). As a result, population and family planning advocates recognized the need to subject the 1969 population policy to a critical review within the context of the Rawlings government's economic and administrative reconstruction program. In 1986, USAID funded the Ghana National Conference on Population and National Reconstruction to offer experienced professionals a forum for frank and objective discussions related to Ghana's population policy. In addition, the conference was intended to stimulate greater public awareness of population issues (Benneh, 1987). The overall recommendations constituting the *1986 Legon Plan of Action on Population* included a call to establish a national population council and the Population Impact Project at the University of Ghana.

As a result of the 1986 conference, the government formally acknowledged the submission of the *1986 Legon Plan of Action on Population*; however, it offered no reaction to the document (Ampem, 1991). In 1989, UNFPA sponsored a second conference, Ghana Population Policy: Future Challenges, to commemorate the 20th anniversary of the 1969 policy. Conference delegates concluded that the tenets of the 1969 policy were still valid, but that the policy itself could be updated by adding emerging issues such as the environment and AIDS. In addition, delegates noted that policy implementation could be strengthened by, among other strategies, involving the newly established district assemblies, which were part of Ghana's decentralization process (NPC, 1994; Ampem, 1991). The 1989 conference reiterated the recommendation to establish a national population council.

Beyond Family Planning: The National Population Council and the 1994 National Population Policy

In 1992, President Rawlings lifted the ban on political parties, thereby permitting democratic elections to take place. At the same time, Ghana adopted a new constitution whose provisions stipulated that the government should maintain a population policy consistent with the aspirations, development needs, and objectives of Ghana and that population issues should receive prominence in national development plans (NPC, 1994).

Reacting to calls for establishing of a national population council in the late 1980s, Parliament in 1992 ratified an act to institute the National Population Council (NPC). Given that the NFPP had not succeeded when housed under the Ministry of Finance and that population issues were recognized as multisectoral and in need of high-level political support, the parliamentary debate focused on where to house the NPC. For these reasons, the act placed the NPC in the Office of the President. One government official said, "This also gives [the NPC] a certain profile and shows the seriousness of the government. It is isolated from interministerial fights and arguments. When the law was written [establishing the NPC], it finally went to the President's office. You need someone who has the President's ear."

In 1994, the NPC led the process to revise the 1969 population policy. The 1994 (revised) *National Population Policy* expanded the reach of population beyond family planning to considerations such as reproductive health, the environment, and housing. In addition, for the first time, the policy formulation process included grassroots participation in population policymaking (NPC Secretariat, n.d.). NPC advisory committees developed action plans for the main components of the policy, including a plan for maternal and child health (MCH) and family planning. Even though the 1994 policy was drafted before the ICPD, it embodied similar recommendations, particularly those pertaining to MCH and family planning. One NPC respondent explained, "Volume 2 (of the Action Plan) was MCH/FP [family planning], but it is really reproductive health. So we had jumped the gun for ICPD."

Respondents generally agreed that Ghana's 1994 *National Population Policy* was, in a subsequently revised form, broader than the 1994 ICPD *Programme of Action*. In addition, the action plans have undergone revision in light of international conferences, such as the 1994 ICPD and the 1995 Fourth World Conference on Women in Beijing (NPC Secretariat, n.d.). One NPC staff member explained the strategy: "If we developed a [comprehensive population] policy today, we would use all of the Cairo recommendations. But [instead of changing the 1994 policy] we have tried to implement it. What happened in Cairo was not explicitly stated in our policy document, this is only guidelines. We consider Cairo recommendations in coming up with strategies; for example, the IEC [information, education, and communication] strategy."
The 1994 revised *National Population Policy* continues to serve as Ghana's major population policy.

Subsequent policies stem from it, such as the *National Reproductive Health Service Policy and Standards* and the *Adolescent Reproductive Health Policy*. Several respondents believed that the 1994 policy was remarkably progressive in focusing on areas later addressed at the ICPD, including reproductive health. A university respondent, however, in voicing criticism of the 1994 *National Population Policy*, said, "I must confess that I did not see many major changes or fundamental change [in the 1994 policy over the 1969 policy]."

Focus on Reproductive Health: 1996 *National Reproductive Health Service Policy and Standards*

While acknowledging that Ghana's 1994 policy addressed reproductive health issues, many respondents noted that the country also needed a separate operational policy to implement reproductive health activities in particular (see Appendix 2 for a list of policies addressing reproductive health). In 1994, the MOH undertook a needs assessment of all levels of public health facilities to determine the information and services available for reproductive health. In reviewing existing guidelines, MOH respondents reported the discovery of parallel guidelines for STDs and MCH activities, noting that other guidelines contradicted each other. In addition, standards spelling out the responsibilities of health workers did not exist. The assessment determined the need for a comprehensive reproductive health policy and guidelines. Therefore, as one respondent commented, the reproductive health policy and standards were "carved" out of the MCH/FP component of the 1994 *National Population Policy*. An NPC staff member noted that "the Reproductive Health and Adolescent Reproductive Health policies are mostly for implementation. The main components were already in the revised [1994] policy."

Accordingly, the MOH directed formulation of the *National Reproductive Health Service Policy and Standards*, specifically to address reproductive health in Ghana. The process involved circulating numerous draft versions of the policy and incorporating the comments of various agencies and organizations. Respondents concurred that the process was highly participatory. A respondent from a U.S. technical assistance organization said, "We were there at the workshop to review and give our comments. It was a tedious process. There were different perceptions of people and the language used, but we got to a consensus." Respondents had a favorable view of the development of the *Reproductive Health Service Policy and Standards* and called the document "explicit" and "exhaustive." At the time of the case study, the MOH was in the process of printing and disseminating the policy to all levels of health care providers.

Developing the Adolescent Reproductive Health Policy

Subsequent to the development of the *National Reproductive Health Service Policy and Standards*, the NPC developed the *Adolescent Reproductive Health Policy*, a draft of which was circulating for comments at the time of the case study. Respondents noted that the policy formulation process was similar to that followed in crafting the *National Reproductive Health Service Policy and Standards* and was highly participatory. Before development of the *Adolescent Reproductive Health Policy*, local consultants—assisted by the Population Impact Project, donors, and technical assistance organizations—completed an adolescent reproductive health assessment for Ghana, which examined socioeconomic, cultural, and political factors affecting adolescent health and welfare, and the implications of these factors for adolescents. One product of the assessment is a directory of institutions working with adolescents. The assessment recommended the formulation of a unified policy on

> "We thought adolescent reproductive health needed a special focus and we developed the [Adolescent Reproductive Health] Policy further."
>
> NPC staff person

adolescents and provided information for organizations interested in undertaking programs aimed at adolescents (Nabila et al., 1997).

Some respondents saw the *Adolescent Reproductive Health Policy* as an extension of the *National Reproductive Health Service Policy and Standards* formulated by the MOH. The link between the policies seems logical; however, the *Adolescent Reproductive Health Policy* does not explicitly mention its connection to the *National Reproductive Health Service Policy and Standards.* Rather, it notes that the adolescent policy responds to the government's responsibility toward young people as noted in the 1992 Constitution and 1994 *National Population Policy*. Moreover, the *Adolescent Reproductive Health Policy* is not an operational policy and instead addresses issues beyond health, including employment and education, without mention of services. The NPC views the adolescent policy as multisectoral in nature. An NPC staff member said, "What is unique about the *Adolescent Reproductive Health Policy* is that it takes health and socioeconomic needs into consideration. The Ministry of Youth only does socioeconomic aspects. The MOH will probably only do health. We marry the two."

B. Structures for Policymaking

Government Agencies

The structures and processes of population and reproductive health policymaking in Ghana are generally lodged in the government, although individuals and organizations outside government have opportunities to participate. The two main government agencies responsible for policymaking in the area of population and reproductive health are the NPC and the MOH. Other government institutions, including the National Council on Women and Development (NCWD) and the Population Information Program, also play a role. With the exception of the NPC, these organizations and other line ministries are responsible for implementing the policies.

National Population Council

The NPC is a parastatal agency that advises the government on population issues and coordinates the population programs of public and private sector organizations. It is made up of 23 individual and institutional members (see Appendix 3 for a list of members). The NPC Secretariat facilitates, monitors, coordinates, and evaluates the implementation of policies and programs, fosters linkages among ministries and agencies, and harmonizes the work of the NPC at the national, regional, and district levels (NPC, 1994). Respondents provided favorable assessments of the NPC, its accomplishments, and its coordination role.

The NPC works with various government and nongovernmental agencies that may or may not be represented on the council, which include the NCWD, the MOH, the PPAG, the Ghana Social Marketing Foundation (GSMF), the Ghana Registered Midwives Association (GRMA), and the Population Impact Project. The NPC advocates a multisectoral approach to policymaking and implementation largely because, as one NPC staff member said, "AIDS and other issues are not just MOH issues." The NPC is not an implementing agency but does provide technical assistance with implementation issues where appropriate. One NPC staff person explained, "The NPC is not involved in implementation. We do follow-up of NPC members… We give technical assistance to groups. For example, PPAG is producing a CBD [community-based distribution] manual and we offer technical assistance. Institutions are going at their own pace, but we assist them to intensify their work."

The NPC has no comprehensive monitoring structure in place

"The NPC coordinates implementation… Each organization is required to report on their programs to the NPC board… We have been given specific assignments. The NPC monitors if we do this."

to track the implementation of population policies; however, member organizations are required to report to the NPC periodically with respect to their progress in implementing policies. Under the provisions of the act that established the NPC, the NPC does not have the authority to enforce its policies; instead, it has instituted five Technical Advisory Committees (TACs) to bring a broader perspective to NPC decision making and to serve as coordinating links to the various implementing agencies (NPC, 1994). The TACs are multisectoral in membership, and their purpose is to reinforce the technical base required for NPC decision making. The five committees cover population policy and programs; family planning services; IEC; research, monitoring, and evaluation; and training. The heads of the TACs form the Technical Coordinating Council (TCC), which coordinates the work of the committees. The TACs oversaw development of the action plans for the 1994 *National Population Policy*. According to both a representative from a U.S. technical assistance organization and a consultant, the TCC is not presently functioning and the TACs do not meet except at the time of budget submission to the Parliament. The consultant commented that "the NPC is not really focused" in reference to following up on the implementation of TAC action plans.

In accordance with the government policy of decentralization, the NPC works closely with regional and district administrative units to ensure that population and reproductive health issues are addressed and that resources are allocated to subnational levels. The NPC Secretariat has set up regional offices, staffed by a population officer, an assistant, and support personnel. The population officer is a member of the Regional Planning Coordinating Unit (a regional administrative office) and can influence regional affairs. At the district level, decentralization plans for the NPC are still being worked out. One of two scenarios will be implemented. Either a District Population Office will be established in each of the 110 districts, or work will continue through the present district structure without hiring additional staff. At present, NPC staff members noted that the second scenario is more likely.

Respondents were optimistic about the NPC's potential for action at the regional and district levels. One donor respondent said, "The NPC puts teeth into decentralization. They are placing population officers in the regions. The challenge now is to make them effective. They are training and making linkages to the district assemblies."

In addition to instituting a presence at the regional and local levels, the NPC has begun a special program supported by UNFPA to build national, regional, and district coalitions. These coalitions, to be formed around various population and reproductive health issues, will be made up of NGOs and interested groups and individuals. The coalitions will serve as additional avenues for influencing local politics and resource allocation for population and reproductive health.

Ministry of Health

The MOH is an important agency involved in population and reproductive health policymaking. It spearheaded the formulation of the *National Reproductive Health Service Policy and Standards* and worked with the NPC on the 1994 *National Population Policy* and draft *Adolescent Reproductive Health Policy*. Respondents generally had a favorable view of the collaboration between the MOH and other ministries and organizations. Although noting that conflicts continue to exist between the MOH and the NPC, respondents said that the problems are not as significant as in the days of the NFPP. A university respondent commented, however, that the MOH continues to want to direct policy development and implementation. He remarked, "This problem still retards advancement today: the MOH wants to lead." In response to the government's decentralization policy, the MOH is restructuring the primary health care system to ensure widespread access to preventive and emergency curative services. Once the decentralization process is complete, a downsized MOH will assume responsibility for operational

policymaking, technical assistance, and advocacy. In each district, a District Health Management Team (DHMT) has been instituted to supervise all clinical and outreach health activities within its jurisdiction. DHMT members serve as health experts for the district and sit on the Social Sector Committee that advises the district assembly on priority health issues for the community and resource requirements for health.

> "There has been a thorough revamping (with help) of the total approach to reproductive health. The MOH takes reproductive health more seriously since Cairo."
> Private consultant

The MOH has broadened its approach from MCH/FP to comprehensive reproductive health. Several respondents noted the influence of the ICPD on the MOH's shift in focus. One MOH official remarked, "The MOH is in transition. We used to have 14 programs. One was MCH/family planning and reproductive health was here. Now it's shifted to 'reproductive health' to look at the entire system of reproduction—from infancy and on through menopause." An MOH researcher noted, "Before Cairo, we only did a few things on reproductive health. After Cairo, we are talking about what else we can do."

In addition to MCH/FP, the MOH addresses HIV/AIDS and STDs. In 1987, the MOH established the National AIDS Control Programme (NACP) to coordinate the national response to the AIDS epidemic. Administered by the Disease Control Unit of the MOH, the NACP works within the decentralized MOH structure to ensure that adequate funding is allocated for STDs/HIV/AIDS at the regional and district levels. In 1990, the MOH instituted an HIV sero-surveillance system to obtain information on the prevalence of STDs and HIV in specific populations, to monitor trends in HIV infection, and to provide information for the evaluation of HIV/AIDS programs (Center for Reproductive Law and Policy and International Federation of Women Lawyers, 1997). In 1992, the MOH published *Guidelines for AIDS Prevention and Control*. The MOH has drafted an HIV/AIDS policy, which is currently under review.

The MOH is also redesigning the national plan for community-based health and family planning programs. It launched the Community Health and Family Planning Project at its Navrongo Health Research Center in northern Ghana to investigate a new approach to developing a community-based, culturally appropriate health and family planning program for rural, traditional African populations (Binka et al., 1995). The project aims to overcome severe ecological, social, economic, and health constraints to both family planning and the use of other reproductive health services (Nazzar et al., 1995). The project reorients the existing national program from passive clinical services to active village outreach, including doorstep delivery service by community health nurses. While service delivery has improved, the project has experienced problems in identifying staff in the local communities and securing housing and local transportation (Adogboba, 1997). Interestingly, only one respondent (with the exception of the representative of the Navrongo Center) mentioned the Community Health and Family Planning Project and its potential contribution to the delivery of reproductive health information and services.

National Council on Women and Development

The NCWD is the government coordinating agency for gender issues and monitors government agencies' policies to ensure that they embody gender components. The NCWD is a member of the NPC and has been involved with the gender coalition and drafting committee of the *Adolescent Reproductive Health Policy*. It has developed education programs, including a small project on women and reproductive health sponsored by UNFPA. An NCWD staff member explained, "We do not duplicate what the NPC does. They do policy issues, they don't implement. NCWD does policy… We implement on a pilot basis. Where we succeed, we hand it over to the NGOs."

Population Impact Project (PIP)

PIP was established to accelerate the momentum generated by the 1986 Ghana National Conference on Population and National Reconstruction. The PIP is an outreach program of the University of Ghana; its goal is to make population information available to policymakers and leaders (Benneh, 1987). PIP activities include dissemination of research findings through publications, presentations, seminars, and briefings at national and regional levels. PIP members work closely with the NPC and serve on the TACs. A number of Ghanaian population experts have been PIP members and have influenced the policymaking process. According to an NPC staff member, "Regarding policymaking, Ghana is lucky we are endowed with famous experts [at the PIP]… They have given us their assistance."

Participation of NGOs and the Private Sector

Respondents agreed that the policymaking process in Ghana is highly participatory. They offered accounts of the involvement of government ministries and agencies, NGOs, private sector representatives, consultants, and donors in the development of the 1994 *National Population Policy*, the *National Reproductive Health Service Policy and Standards*, and the *Adolescent Reproductive Health Policy*. An NPC staff member remarked, "Regarding policymaking, there is participation at all levels. All are involved: NGOs, etc.…" NGOs and the private sector are also highly involved in policymaking at the regional and district levels.

> "Yes, we have input. We attend regular [NPC] meetings according to the subject of the meetings… The process is quite open, and we can come in with our interests."
>
> NGO representative

NGOs exercise influence through several policymaking channels. Nationally, representatives of three NGOs are members of the NPC, and as noted, NGO representatives serve on the TACs, although participation is limited to international and national NGOs. A wider spectrum of NGOs have input in policy development at the regional and district levels. In addition, NGOs may be members of the NPC coalitions at the national, regional, and district levels.

While the private sector is involved in national population policymaking through the Ghana Medical Association's (GMA) representation on the NPC, respondents varied in their assessment of the adequacy of that representation. A respondent from a social marketing NGO explained, "Regarding policymaking, private practitioners are not invited… The GMA is included, but it doesn't represent the varied private sector interests. The private sector is not represented on the NPC." A representative from a U.S. technical assistance organization noted, however, that various private sector members serve on the TACs and that physicians from the teaching hospitals often function as resource persons.

Respondents believed that private practitioners would participate more actively in reproductive health programs and services if the practitioners were better educated about the benefits of a reproductive health approach. They recommended that the MOH and the NPC spearhead efforts to educate the private sector about reproductive health in general and family planning in particular.

Decentralization

The success of Ghana's population and reproductive health policies and programs depends to a large extent on the government's decentralization process. Financial resources and planning authority have been transferred to 110 district assemblies, which are charged with facilitating government development initiatives and providing social services for residents of their constituent communities (Nabila et al., 1997).

Sector ministries, including the MOH and the NPC, are also decentralizing and will work with the district assemblies to ensure that the planning process incorporates family planning and reproductive health issues and allocates adequate resources to these activities.

Decentralization provides both opportunities and challenges for the development and implementation of reproductive health programs. Communities will be able to develop programs that are more responsive to their needs; local rather than national development of programs will likely spur a deeper community commitment to successful program implementation. Furthermore, at the local level, many individuals and groups that would never have a chance to express their needs and interests will have an opportunity to participate in the program development process.

> "The buck stops with them [the district assemblies]. They are in charge of their own stuff."
> University respondent

On the other hand, many local leaders and administrators lack needed planning skills or a technical understanding of the importance of preventive health in general and reproductive health in particular. One respondent from a U.S. technical assistance organization said, "They see the Vision 2020 and the 1994 population policy all spelled out. But they are not told how they can do this in the districts. They haven't woken up to the fact that they have a major role to play."

> "There is new change on the ground… So we need to convince the district assembly that health is important [enough to devote] resources to it. We need to really lobby them about why health is important because there are so many other [competing issues for limited resources]. "
> Government official

Respondents concurred that education and advocacy are essential to ensuring that district assemblies recognize the significance of local health needs and allocate resources accordingly. Most respondents agreed that district officials are not aware of the health and population issues in their own communities, especially when issues of revenue generation, industry development, and infrastructure, for example, compete for attention. One respondent from a U.S. technical assistance organization explained, "In order to get more money to health, the MOH needs to convince the district assembly to allocate more money to health. They have to defend the budgets at the district level."

Various structures are already in place to promote education and advocacy for population, health, and reproductive health at the district level. The MOH's Health Education Unit is working with local officials. The NPC is decentralizing and setting up regional and district coalitions; the NCWD has established regional and district offices and coordinates with cooperating organizations. NGOs also work with the districts to "make sure the issues are in their development plans" (NGO respondent). In addition, local NGOs are beginning to form networks for purposes of working with district assemblies. One network member noted, "At the district level, we try to get the information to the district assemblies. Because the idea is to get them to know what is happening in their areas and put this in their plans. We briefed the district assembly [in one district] so far. They have ideas of teen pregnancy as a problem, but they hadn't noticed they need to take action."

In the matter of educating district officials, several respondents noted the importance of using district-level statistics instead of regional or national statistics. According to a respondent from a U.S. technical assistance organization, "The policymakers take these figures more seriously." District statistics are difficult to produce, however. One DHMT representative interviewed for the case study had collected local public and private hospital figures on HIV/AIDS to highlight the epidemic. The team member recalled, "AIDS is a problem but not a priority [for the district assembly]… Health is not their priority, but they

listened well. Now to get them to contribute is the problem. They are more concerned with revenue generation."

District assemblies are responsible for budgeting available resources according to their five-year district development plans. District funds are available from three main sources: locally generated revenues; the district assembly common fund (distributed by the Ministry of Local Government); and donor and NGO support. Sector ministries also allocate resources to the district level; however, these funds are not recorded in the district budget and will decrease as the decentralization process is completed. For example, at present, the MOH may build a new health post and pay for it out of central MOH funds. In the future, the district itself will have to build and upgrade needed health facilities. According to the district officials interviewed, the common fund is presently the largest source of funds available to the district assemblies. This situation will change over time, however, as districts become responsible for generating more of their own revenue.

In cases of funding gaps—for example, a gap between the DHMT's budget for health expenditures and the district's allocation to health—the district officers interviewed noted that it has been easy to solicit donor and NGO funding to make up the shortfall. A DHMT representative voiced disagreement, however. It is important to note that the district in question is near Accra and has a history of strong donor support. Such access to supplemental donor and NGO assistance may not be so readily available to each of Ghana's 110 districts. A DHMT administrator said, in many cases, "There is no money for making up gaps."

C. Definition of Reproductive Health

When asked about the impact of the ICPD on the policy formulation and implementation process in Ghana, several respondents said that Ghana had been focusing on reproductive health issues before the Cairo conference. Respondents were proud of their achievements in reproductive health and felt that events in Cairo justified their vision. Nonetheless, since the ICPD, Ghana has refined and more broadly applied the concept of reproductive health. A representative from a U.S. technical assistance organization summed up Ghana's progress relative to the ICPD by saying, "Cairo came to cement some of the things we are doing, and it gave impetus for refocusing and strengthening other things we are doing."

> "Post-ICPD? Where to begin? Most things we were already doing. We were lucky to have a vision before 1994."
>
> NPC staff member

During the policy formulation process that guided development of the *National Reproductive Health Service Policy and Standards*, Ghana adopted the ICPD definition of reproductive health and included it in its policy document. Respondents were well versed in both the Cairo definition and the individual elements of reproductive health. They pointed out that the definition of reproductive health has been expanded beyond MCH/FP to include other issues and other population groups in addition to women of reproductive age. Several respondents noted that family planning nonetheless continues to be the mainstay of reproductive health. An MOH respondent said, "There is a difference between MCH and reproductive health. Reproductive health talks about everybody: men, women, children, youth. I still say women will be the focus because they bear the brunt of the illnesses." Several respondents concurred that the focus on women should continue to dominate. Others included STDs, HIV/AIDS, postabortion care, infertility, cancer, sexuality, and adolescent issues in the definition of reproductive health.

A recurring theme in the interviews was the recent focus among the government and NGOs on male involvement. Respondents generally agreed that the gap between knowledge and practice in family planning and utilization of other reproductive health services, by women and men, stems from male

attitudes. Several respondents mentioned that several organizations, including the PPAG, have initiated specific male education programs and services. According to a PPAG respondent, "The male aspect is a post-ICPD issue. We are interested in males more—the forgotten 50 percent are brought into the action."

Unfortunately, knowledge of the ICPD definition of reproductive health has not filtered down to community-level health workers. Several respondents noted that the MOH addressed reproductive health issues long before Cairo and that health workers may understand the separate elements of reproductive health but not recognize them under reproductive health. A representative from a U.S. technical assistance organization commented, "These international ideas come along and they want to categorize everything and push single ideas… A health post may be baffled if you ask about reproductive health if they have not read the guidelines [and thus have not seen the term 'reproductive health']. But if you ask about each element, then they will say they offer them all." Distribution of the *National Reproductive Health Service Policy and Standards*, which includes the ICPD definition of reproductive health and details about each element, should bring about wider recognition and understanding of the concept.

> "People know reproductive health areas one by one. The term itself is difficult and hard to understand by health workers."
>
> MOH official

Priorities

The MOH's priority areas include several elements of reproductive health, most notably maternal and child care, family planning, nutrition, control of diarrheal disease, malarial control, immunizations, health education, and STDs and HIV/AIDS (GSS and MI, 1994). The *National Reproductive Health Service Policy and Standards* covers all elements of reproductive health with the exception of maternal and infant nutrition, adolescents, and gender-based violence (MOH, 1996a). The MOH determined priorities by analyzing available data. An MOH official explained, "These [priorities] are determined by indicators. The MMR and IMR are so high. We don't know the prevalence of STDs, but we see HIV increasing, so we know there are problems with STDs. So we have data to tell us. With family planning, the fertility rate is so high that we want to bring it down." Regarding HIV/AIDS, a representative from NACP stated, "AIDS is a priority because of prevalence. Currently, it is estimated at 4 to 5 percent for HIV and if the trend continues, it will be 8 percent by the year 2005."

Respondents from all sectors agreed that adolescent, HIV/AIDS, and family planning services are priority issues in reproductive health. Citing the associated problems of teen pregnancy and HIV, respondents viewed programs and services for adolescents as an obvious area of need. An NPC staff member commented, "There is lots of focus on adolescent reproductive health because it was identified as a priority in Cairo and Beijing. We see kids on the streets selling things. The number of adolescents, the jobs needed, the potential for HIV. You can see the problems clearly." Many organizations, including NGOs and religious groups and churches, have established youth centers and youth programs that offer peer reproductive health counseling and education. A respondent from the private sector believes that adolescent services make good business for the private sector. Support for an explicit policy to address adolescent reproductive health attests to the priority status of adolescent reproductive health in Ghana.

Although female genital mutilation is not a high priority for the MOH or the NPC, the issue has been widely publicized in Ghana. Women's organizations and international human rights groups were instrumental in gaining passage of the 1994 FGM law. Educational campaigns that have included a television documentary have been mounted to combat the practice. A representative from a U.S. technical assistance organization said, "There is not much activity [by the NPC] on female genital mutilation for

want of time and focus. It is part of the *Adolescent Reproductive Health Policy*, though."

Respondents recognized that reproductive health priorities differ between regions and districts. The decentralization process highlights the need for regional and district assessments for local priority setting.

D. Support and Opposition

Political Support for Reproductive Health

> "The president is very much concerned with population growth… The president sometimes talks himself and uses himself as an example. This assists us a lot. People are more prepared to listen when the president has a view on it."
>
> Parliamentarian, member of the population caucus

Despite widespread support for population and reproductive health issues in Ghana, respondents questioned the depth of commitment on the part of government officials and religious and community leaders. While these leaders are not actively opposed to reproductive health, they are not particularly proactive in advancing the reproductive health agenda. Respondents were thankful that the government was "at least not an antagonist" (university respondent) during hard-fought policy formulation or budget allocation battles. One consultant stated that, with respect to the NFPP, "[The government] didn't spoil it, but it didn't support it either." Such a lack of active support left respondents believing the government could do more to push the reproductive health agenda. At the local levels, little government support for population and reproductive health is evident. Respondents believed that the limited support reflects a lack of knowledge and awareness on the part of local administrators rather than explicit objections to population and reproductive health issues.

Several respondents observed a change in the government's political will since the late 1980s. The president and first lady are now influential supporters of population and reproductive health. Although President Rawlings has been in power since 1981, he did not show strong support for population issues until the early 1990s. An MOH official said, "Everywhere he [President Rawlings] goes, he talks about population and its effects." During a visit to neighboring Burkina Faso in December 1997, President Rawlings spoke to rural women about family planning.

The first lady, a strong supporter of population and reproductive health issues, led the Ghanaian delegation at the ICPD. A university professor and PIP member explained that the PIP educated the first lady on population issues and she, in turn, convinced the president: "We gave a presentation to the first lady. [She then influenced the president], and he became the number one advocate of family planning." Several respondents noted, however, that the president's support is merely verbal and does not translate into adequate funding for population and reproductive health activities. One parliamentarian, who is a member of the population caucus, stated, "The government's attention has been focused on provision of basic infrastructure because of the shift from a socialist system to a capitalist one. Little is left in the budget for population and such issues. You can't see the president's concern in the budget!"

With aid from the Parliamentarians for Global Action (PGA), Parliament has established a caucus on population that is currently trying to establish a permanent committee for population. In December 1997, the PGA sponsored a conference to discuss post-ICPD issues among Ghanaian and Senegalese parliamentarians, although attendance did not go beyond PGA members. Given that Parliament is influential in ratifying policies and laws, voting on budgets, and influencing other government bodies, such as district assemblies, its support is extremely important.

With respect to religious groups, respondents believed that they do not offer "any significant opposition" to population and reproductive health programs. They are opposed to specific reproductive health issues but not to reproductive health in general. The Catholic Church is opposed to television advertising of contraceptives and to some family planning methods. One representative from a U.S. technical assistance organization said, "The Catholics don't do sterilization. But they are also not against it. They just don't want to promote it." Muslims are opposed to public sex education and public discussions of family planning. Religious groups are involved with adolescents, and several have created youth centers and youth education programs. The PPAG, in particular, works with religious organizations to reach youth through church structures. Overall, religious groups are generally supportive of information and education about reproductive health issues.

> "There is not really an objection to reproductive health [among the public], but a lack of awareness. People are not really conservative. If you talk to them, they have the wrong impression of family planning and reproductive health because earlier the talk was of only family planning, and reproductive health is new since 1994. A lot of people haven't got this in their minds yet. When we explain, all people say this [reproductive health] is something we should all address."
>
> Representative of a technical assistance organization

Chiefs and traditional leaders offer some support for reproductive health. A respondent from a U.S. technical assistance organization commented, "Chiefs and traditional leaders are no problem. In fact, chiefs are present [to receive family planning in the clinics]. They may not encourage it, but they are not against it."

Knowledge of Reproductive Health

Knowledge of the concept of reproductive health among population policymakers and program managers is high. This group of population elites follows international developments and is working to implement the ICPD *Programme of Action* in Ghana. Policymakers and program managers can readily cite reproductive health terminology, the elements of reproductive health, and the ICPD recommendations. Knowledge below the elite level is not extensive, however. Respondents attribute the gap to the failure to disseminate the ICPD recommendations and reproductive health information. They believe that Ghanaians in general would support reproductive health programs if they were educated about them.

Although parliamentarians in the population caucus support reproductive health, they continue to focus on population growth and economic development arguments. One parliamentarian member of the caucus noted that the group's knowledge deepened before and after the ICPD, largely because the PGA sent members regular ICPD updates by fax and mail. This caucus is a small group, however, and a uniform level of interest and knowledge does not cut across all parliamentarians.

Several respondents mentioned that many public and private sector providers do not know the term "reproductive health" and do not offer reproductive health services. The MOH is trying to educate public providers at all levels while it disseminates the *National Reproductive Health Service Policy and Standards.* Private providers may be harder to reach because they are not required to implement reproductive health policies as part of their practice. A social marketing representative stated, "The private sector thinks family planning is a waste of time. They can make more money from malaria than from a family planning client. So a number of them are not really interested, but some are." He continued, "Some physicians think if they promote family planning it would kill their lucrative abortion business. But a

woman seeking an abortion is a clear sign that she needs family planning! She is the demand. It is very difficult getting this through to them."

Despite public and private providers' lack of familiarity with reproductive health, knowledge of specific reproductive health issues, mainly family planning and HIV/AIDS, is far-reaching in Ghana. Several respondents quoted the 1993 Demographic and Health Survey (DHS) with respect to the Ghanaian population's universal knowledge of family planning methods and AIDS. A representative from a U.S. technical assistance organization commented, "This high level of awareness is good. It's great!" Others noted that although knowledge of AIDS is widespread, people do not believe it is "real" and that it could affect them personally. In a qualitative study undertaken by the MOH, none of the persons interviewed considered AIDS to be a major problem (MOH, 1993). Respondents agreed that the challenge now facing the reproductive health community is to increase the practice of family planning and HIV prevention behaviors as well as the utilization of reproductive health services.

4. Policy Implementation

A. Operational Policies and Plans

> "People wanted guidelines. The problem was a lack of job descriptions and protocols. The [Reproductive Health Service] Policy spells out some of these things."
>
> MOH respondent

The *National Reproductive Health Service Policy and Standards* function as the primary operational plan for MOH implementation of reproductive health services; the guidelines and standards are applicable to all service providers, public and private. The document consists of two parts. Part I, the guidelines, describes the components of reproductive health services; the rules and regulations governing reproductive health services and training; target and priority groups for services and IEC; persons eligible for services; providers who will provide specific services; and the way training, logistics, supervision, and evaluation activities will be planned and implemented. Part II, the service standards, describes the minimum acceptable level of performance and the expectations for each component of reproductive health services; the expected functions of providers; and the various levels of service delivery and basic training content required for the performance of the several functions. The *National Reproductive Health Service Policy and Standards* are also meant to assist in monitoring and evaluating service availability, accessibility, quality, and utilization (MOH, 1996a).

The MOH is in the process of disseminating the *National Reproductive Health Service Policy and Standards* to all levels of health care providers. An MOH official said that regional representatives have been trained to disseminate the contents of the document to further levels of users. He remarked, "Most of the time when a policy is formulated, it doesn't go down to the users… [This time], we will have a workshop to introduce all users formally." Some private sector providers and NGOs have received the policy and are using it in their operations. The MOH maintains a dialogue with private doctors and midwives to see that the *National Reproductive Health Policy and Standards* are used in the private sector.

B. Service Delivery Structure and Implementing Agencies

Ministry of Health

The MOH provides 30 percent of health services in Ghana (MOH, 1996b). Primary health care services are divided into a hierarchy within the MOH: teaching hospitals and regional hospitals; district facilities, including hospitals (Level C); rural clinics staffed by paramedics (Level B); and village health posts staffed by volunteers or organized by outreach workers (Level A). As is the case in many developing countries, the structure creates a system shaped by the requirements of treating rather than preventing illness. In addition, rural populations remain underserved while Level A health posts are rarely operational (Nazzar et al., 1995). MCH clinics are stand-alone facilities or attached to hospitals.

Two main divisions in the MOH provide reproductive health services. The Primary Health Division focuses on preventive care through the MCH/Family Planning Unit; the Disease Control Unit, which coordinates HIV/AIDS and STD prevention and management; the Health Education Unit, which develops IEC plans and programs; and the Nutrition Unit, which handles maternal and infant nutrition. The Institutional Care Division focuses on curative services and oversees MCH hospitals and sick child services. The MOH offers services for most reproductive health elements, except gender-based violence (see Appendix 4) (Center for Reproductive Law and Policy and International Federation of Women Lawyers, 1997). At this stage, some elements such as infertility and menopause are addressed only through counseling. The MOH is developing a cancer program and is planning a baseline survey to determine the incidence and prevalence of the disease.

A university respondent commented that although reproductive health services are relatively comprehensive, special groups remain unserved. She said, "There are no programs for menopause, infertility, or for those who don't want any children. Or, if you are not pregnant, there are not services for you. Mental illness is also not addressed." Several respondents noted that reproductive health services are primarily targeted to women, with no comprehensive services offered for adolescents and men.

The DHMT representative interviewed for the case study expressed the opinion that most reproductive health services are available at the district level or that referral mechanisms are in place for further examination and treatment. He explained that the DHMT outreach program in underserved areas "treats all things: family planning, antenatal, STDs, fever, whatever is there." Some services, such as antenatal care, are offered only on specific days of the week, however. The district staff works with adolescents and visits schools for examinations and referrals and to give health talks. The staff is also involved in an AIDS education project, including visits to Catholic groups.

As a result of the ICPD, both the university public health program and the medical schools have modified their curricula to incorporate reproductive health issues and training. A university professor noted, "We are very engaged in following what is happening in the world—the shift from just MCH to gender and reproductive health… Everybody now agrees we need to look at all of human reproductive health as an important part of public health. I'm sure Cairo was very important in changing things."

NGOs

International, national, and local NGOs are involved in promoting reproductive health in Ghana. Most NGOs offer information and education with regard to reproductive health, but only a few provide services. The largest NGO involved in reproductive health service delivery is the PPAG, which offers family

planning, some antenatal and nutrition services, and STD, infertility, postabortion care, and menopause counseling services. In addition, the PPAG has started pilot male clinics to counsel men about problems such as impotency, domestic disputes, contraceptives, and STDs/HIV. Regarding STDs, a PPAG representative stated, "We haven't been able to do much here. Counseling, but no service provision. We are not able to do tests, so we refer to government hospitals. In one or two clinics, some doctors have done a bit more [to treat STDs] on their own." The PPAG is also operating a pilot women-and-development project in northern Ghana that has created a women's center where women can discuss their problems. The center offers clinical services and innovative income-generation activities. Further, the PPAG hopes the center will trigger community discussions about female genital mutilation.

> "I always feel the recognition of the role of NGOs in quite high… We are looking at non-implementation and the need for NGOs there. We have given support to NGOs. We see how they should help us in the future."
>
> NPC staff member

Save the Children Fund is another NGO fielding a large reproductive health project that includes service provision. The project's clinics offer safe motherhood and STD/HIV services, including community-based support for persons living with AIDS. In addition, the project trains traditional birth attendants (TBAs) and has launched income-generation activities (Save the Children Fund, 1997).

NGOs are instrumental in providing services to underserved and disadvantaged populations in Ghana, including rural residents, commercial sex workers, truck drivers, miners, and persons living with AIDS. Several government officials—from the national to the district level—recognized the value of NGO involvement in certain geographic areas and with groups that the government cannot reach. NGOs work with the MOH in training and implementation. National and community NGOs are heavily involved in district development. According to one district official, "NGO support is written into our development plan," and the district relies on NGO and donor funding to fill in service gaps or to target issues the district does not consider as priorities.

Private Sector

The private sector, which comprises physicians, pharmacists, chemical sellers, and midwives, provides 40 percent of health services in Ghana (MOH, 1996b). The Family Planning and Health Project Tracking Study revealed that the private sector is the source for more than 70 percent of short-term family planning methods and more than 50 percent of all methods. In addition, several respondents noted that the private sector handles most STD cases.

> "More than 50 percent of the people with STDs try private sector services of some kind."
>
> Consultant

Midwives are an important source of reproductive health services in Ghana. There are more than 6,000 midwives in Ghana compared to fewer than 2,000 physicians. Physicians are mainly clustered in large cities, whereas midwives are widely dispersed throughout the country, particularly in Ghana's rural areas (Otsea et al., 1997). Many midwives belong to the Ghana Registered Midwives Association, which in conjunction with MotherCare and the MOH is training and equipping public and private midwives to provide postabortion care and emergency reproductive health services (Otsea et al., 1997). The rural midwife interviewed for the case study offers safe pregnancy, STD, nutrition, and family planning services and was planning to be trained in postabortion care in the near future. If she does not provide services herself, she taps the referral system to send patients to nearby physicians and the health post and hospital. She also delivers lectures to churches and other groups on reproductive health subjects.

Several respondents also pointed out that traditional medicine is still practiced in Ghana, especially for reproductive health problems. Traditional healers and spiritualists are often the first source of care for many illnesses, including STDs and HIV. Patients may seek the care of a traditional healer when medications such as AZT for AIDS are not available to them or are too costly (Awusabo-Asare and Anarfi, 1997).

C. Integration

> "Now the MOH is making STDs a major part of the family planning program."
> Representative of technical assistance organization

The integrated approach to the provision of reproductive health services has developed over time in Ghana. Respondents noted that Ghanaian policymakers decided early on that maternal health and child health services should be offered together. In furtherance of the approach, the basic mix includes other services as well. One MOH official said, "We have MCH. It started with this. Now we only need to add reproductive health activities."

At this point, full reproductive health service integration does not exist within the MOH, and there are linkages only between selected components, mainly MCH and family planning linked to STD, HIV/AIDS, and postabortion care services. When questioned about the integration of services, most respondents referred to the linkage between family planning and STD services. An MOH official said, "Now we are integrating STDs into MCH to counsel and treat reproductive health. We want to give a reproductive health mentality to health workers." Currently, a pilot project is underway in two regions to integrate the management of STDs into family planning services.

MotherCare is training some public and private midwives and physicians in postabortion care, including postabortion family planning. A respondent from a U.S. technical assistance organization working with the project noted that family planning clinics are often separate from the emergency obstetric services of the MOH. In such cases, midwives and physicians providing postabortion care make referrals for family planning. The respondent said that technical assistance organizations are pushing for facilities integration as well. "We are trying to put the family planning services in the emergency clinics, too."

The *National Reproductive Health Service Policy and Standards* define the responsibilities of each type of service provider and outline training strategies to ensure that all providers are skilled in all reproductive health components. Providers at all levels are responsible for some type of service delivery for all reproductive health elements—whether it be treatment or assessment and referral. Respondents from several organizations noted that referral systems are in place within the MOH and between NGOs and the MOH.

Interestingly, one representative from a U.S. technical assistance organization questioned the definition of service integration and believed that the MOH has been providing integrated services all along through its established referral systems. She doubted that reproductive health service integration requires a new service delivery structure within the MOH. She explained, "The MOH already had integrated services before ICPD. They were not labeled reproductive health, however. A hospital…gives all health care. If someone has cancer and can't be treated [somewhere], there is a referral system in place… What is integration? Does it have to be one person providing all?"

Two university respondents exchanged comments about the integration of services proposed by the *National Reproductive Health Service Policy and Standards*. They argued that the MOH did not consider the available manpower, skills, supplies, and equipment when it formulated the framework for integration.

In addition, they pointed out that the framework has not been tested in the field. One respondent commented, "The understanding of integration is a problem. Each provider has his own idea." The other followed, "What to integrate at what level? Some kind of framework is in the reproductive health policy. But you need to look at what is available at each level, and they [the MOH] haven't done this." The other continued, "My problem is the policy is too grand. We need to see by trial and error what works. It is dictatorial. It says this is the policy and assumes it will work… Ghanaians think if you just make guidelines and standards, then it will happen! The MOH is too set on looking from the top down rather than the bottom up."

NGOs are also trying to promote service integration, but with limited success. The PPAG acknowledges that it does not offer all reproductive health services and that its services are completely integrated. "We use a holistic look at women's reproductive health problems. We are doing a bit in our clinics [to integrate]… We are not able to do [STD] tests, so we refer to government hospitals… We don't have the money to equip [our clinics with everything]."

Several respondents expressed the view that simply adding more responsibilities to health workers' duties is not what is meant by integration. One NGO representative noted, "The MOH does integration, but there is room for improvement. For example, with nurses, there is so much work for them. They do not have time to sit down." Moreover, health workers are often not compensated for additional skills. An NGO respondent commented, "We are training workers, but as work expands, we can't pay them more or hire more."

With respect to counseling, the NGO respondent continued, "One-on-one [counseling] is a problem. For women with marital problems or menopause, you need time to talk or visit women at home." Several respondents pointed out the obstacles to providing high-quality counseling: the lack of space for private conversations, insufficient time for health workers to talk to people, or the limited availability of appropriately trained workers. One representative from a U.S. technical assistance organization stated, "What is needed is counseling skills. Real counseling, not just advice." The PPAG has initiated a relationship with a psychology professor who will train PPAG personnel in counseling skills. But, as observed in the case of HIV counseling, it becomes an additional responsibility for those trained in counseling (Awusabo-Asare and Marfo, 1997).

NGOs, particularly the PPAG, work with the MOH in training and service delivery. For example, the MOH administers immunizations at some PPAG clinics. Save the Children Fund also implements its program in close collaboration with the MOH. A representative from the organization explained, "In the north zone, we provide nurse/midwives, train TBAs, and give technical support to the MOH. The MOH provides the services. Some of our clinics have their own services, but we work with the MOH in the area." The MOH's Private Sector Support Unit coordinates with NGOs.

D. Constraints

Sociocultural Barriers

There was consensus among respondents that Ghana's sociocultural mores impede the implementation of reproductive health policies and programs. In particular, respondents pointed to a pronatalist society and traditional gender roles. Several respondents, however, believed that the

> "There is pressure from mother, husband, friends, and society to have more children. This culture needs to change."
>
> MOH respondent

situation is changing and that people are starting to recognize the monetary and other costs associated with a large family. A representative from a U.S. technical assistance organization said, "Society places a lot of value on many children—to show you are a man. I think these things are changing."

> "There is some focus here [AIDS], but it needs to be brought out more. People need to know it is a real thing."
>
> NRC staff member

Respondents noted several ways in which the dominance of men in society is detrimental to both men's and women's reproductive health. They remarked that men make decisions that influence reproductive health, particularly with respect to engaging in unprotected sex (which increases the risk of HIV and STD transmission) and taking advantage of reproductive health services, especially family planning. A woman in union cannot refuse to have sexual relations with her husband (Awusabo-Asare et al., 1993), and women may not have a say in using a condom; in addition, men may know they have an STD but not tell their partner. A respondent from a U.S. technical assistance organization noted, "The man has the upper hand in sexual matters. Women have no say in using protection." Men also control the resources needed for reproductive health treatment.

> "Culture is important to family planning and reproductive health. Men are in control of everything. People don't see men as an important part of reproductive health. I know this will change..."
>
> Representative of a technical

Most respondents believed that the solution to overcoming the above obstacles lies in male involvement: educating men about the reproductive health of both men and women and promoting the use of services, particularly family planning. An MOH official said, "The major thing I consider is the male factor. All along it has more or less been sidelined. But if you take our situation in Ghana, it is so male-dominated. Even if a woman sees the need for family planning, she must get her husband's permission. There is a lot of evidence of women doing it on the quiet. Now how to get men to let women decide?" Thus, respondents noted that in addition to empowering women to make their own decisions regarding contraception, it is crucial for men to understand the reproductive health benefits of family planning. A shift in male attitudes is essential to ensuring that women receive needed services; however, men need reproductive health services as well, such as for contraception and treatment of impotency and STDs/HIV.

Depth of Awareness of Reproductive Health

Several respondents noted that although knowledge of reproductive health issues is generally high in Ghana, the depth of understanding of the issues is problematic. They mentioned the lack of recognition on the part of district officials, but specifically, the lack of clear understanding among all levels of health care providers of the magnitude, consequences, and means of controlling the HIV/AIDS epidemic. Some respondents felt that Ghanaians—including policymakers and program managers—do not believe HIV/AIDS is "real." An MOF official said, "In certain areas [of the social sector] it takes a longer time for a disaster to blow over, so people start to ignore it. With AIDS in particular, we need to convince the top level that it is real. In the next 20 years we may wake up and it will take massive resources away from the health sector."

Lack of Infrastructure and Trained Personnel

Several respondents expressed the view that Ghana's basic infrastructure for the delivery of reproductive health services is deficient. Poor access to services in rural areas is a notable problem. The MOH is not able to serve these areas adequately and NGOs are not able to fill the gap. An MOF official commented, "The program needs to massively get into rural Ghana… If we don't make an impact there, then I'm afraid

we won't make an impact at all." Respondents also noted that supervision and monitoring are weak. One MOH official admitted that although supervisory mechanisms exist, central staff members do not have sufficient time to travel to the field for supervisory visits.

In addition to a lack of facilities, health personnel in the public, nongovernmental, and private sectors are not trained to identify and deliver reproductive health services; meanwhile, the overall quality of care is not high. Even though the *National Reproductive Health Service Policy and Standards* sets forth minimum standards for skills and training by type of service provider, Ghana lacks an overall strategy to train workers in the necessary skills. One donor explained, "Reproductive health is comprehensive. No one can implement all those services in the developing world. You must do it incrementally. You must train health workers slowly. And whether they can grasp all of this is another question." With respect to quality of care, an NGO representative said, "I like to think quality of care is high with us [NGOs]… There is a need for all providers to get trained for quality of care. It is virtually lacking in all places."

Limited Financial Resources

When asked about constraints to the implementation of reproductive health programs, most respondents immediately mentioned financial resource limitations as one of the chief obstacles to making available a full range of reproductive health services. An NGO respondent said, "We could do so many things with more support." Respondents noted that both the government and donor agencies need to provide more funds.

> "The problem is this: Most of these things [reproductive health services] cannot happen [without funding]. We have ideas in Ghana. We need the money to push them forward and then monitor and supervise them."
>
> MOH official

Lack of financial resources is also a problem for clients. Several respondents pointed out that insufficient money for transportation and service fees presents would-be clients, especially those in rural areas, from partaking of the available reproductive health services. A member of the DHMT said, "The problems are distance and cost. It is not easy to find a car [to bring a woman in] for antenatal care."

5. Resource Allocation

A. Funding Levels for Reproductive Health

With various health activities divided among government agencies such as the MOH, NPC, NCWD, and PIP, it is difficult to calculate the funding committed to reproductive health in Ghana. As for health generally, the government proposes an allocation of 10 percent of capital and recurrent expenditures for 1996–2000 health (NDPC, 1995). One MOF respondent had the opinion that "the government of Ghana does spend a large bulk on health."

A representative from a U.S. technical assistance organization, however, noted that the NPC budget is a useful gauge for determining most population funding. The NPC budget does not, however, include MOH reproductive health activities; furthermore, NPC activities are not devoted solely to reproductive health. Nonetheless, the government budget includes a line item for the NPC and its programs, which respondents viewed as the government's indication of the importance of the council's work. An NPC staff member stated, "We achieved an extra budget line item for programs. The MOH doesn't have this. 230 million

cedis [approximately US$107,000] to do our programs for 1997. This is apart from donor money. This year we are trying to get 315 million cedis [approximately US$146,000]." The United Nations estimates that the resource requirements for population and reproductive health programs in Ghana will total almost $US66 million by the year 2000, jumping to US$123 million by 2015 (United Nations Population Fund, n.d.).

B. Major Donors

The primary donors in the area of population and reproductive health in Ghana are USAID and UNFPA and, to a lesser extent, the European Union, the Danish International Development Agency (DANIDA), the Japanese International Cooperation Agency (JICA), the United Kingdom Department for International Development (DFID), and foundations. While one NPC staff member responded that the government has started to increase its funding for population activities and "that there is not an overdependence on donors currently," other respondents concluded otherwise. Several noted that the role played by donors and NGOs is crucial to providing information and services to underserved populations, especially at the district level. One donor and one government respondent commented on a particularly high degree of external assistance and dependence on donor funds.

The government is implementing a new, national, broad-based budgeting system, whereby donor funds for all development sectors are channeled through the government rather than directly allocated to the ministries or agencies, such as the NPC or the MOH. Under the system, government sectors are expected to develop their programs irrespective of donor funding. According to an NPC staff member, programs will then become "more country-driven rather than donor-driven." In addition, the MOH is instituting a common fund that the ministry will manage in accordance with its established programs and priorities (MOH, 1996b). The fund, it is hoped, will lead to more efficient management and coordination of donor funds. A representative from a U.S. technical assistance organization commented, "The MOH wants to be in the driving seat and make sure things get done." Not all donors have yet signed onto the common fund, however.

6. Challenges

In addition to the implementation constraints already mentioned, Ghana faces other challenges to the development and implementation of sound reproductive health policies and programs.

Strengthening Political Support for Reproductive Health

Respondents recognized that formulating legislation, including signing on to international agreements, is important for promoting and legitimizing population and reproductive health issues in Ghana. Several respondents noted that the ICPD had a legitimizing effect on the population and reproductive health work already underway in Ghana. An NPC staff member said, "We live in a global world. Our programs are also in ICPD. So Ghana is not working alone. It gives even more credit to what we are developing… It makes acceptance of our programs easier." In addition to legitimizing current work, signing on to international agreements gives both the government and NGOs bargaining power. For example, several

> "The major problem for implementation [of the NFPP] was that people who were to implement didn't even believe!… Even ministers didn't think family planning was important. Even the MOH! Implementation suffered because of this. They didn't make population an integral part of development planning. They always stuck population issues at the end."
>
> University respondent

respondents pointed out that their respective government agencies and NGOs are able to hold the government accountable for the promises it made by signing the Cairo and Beijing documents. An NCWD respondent commented, "The government made a contract in Beijing. We can call on the government to do what it signed."

At the national level, several respondents noted that the NPC was established by an act of Parliament, thus validating its role as a permanent government body. A university professor said, "Parliament had an act to set up the NPC… It was an act of Parliament to back it up. You can't just abolish it!" In contrast, the NFPP was not established by an official government act. One university respondent explained, "[The NFPP] was conceived with a lot of urgency in Ghana, so we couldn't wait for a policy to be made into legislation." Respondents felt that an act of Parliament would have justified the NFPP's importance for the purpose of gaining political and financial support.

Clearly, policy development and, in particular, program implementation in Ghana have become more effective as a consequence of the international backing of the Cairo and Beijing conferences, the government's political commitment, and the legislation creating the NPC.

Translating Policies and Knowledge into Practice

Following from policy formulation at the national level is the challenge of putting Ghana's population and reproductive health policies into practice. The consensus among respondents was that Ghana has formulated "great policies," but that implementation remains inadequate. An MOH respondent noted, "Ghana has choked up the system with policies, but we see no results." Respondents suggested several measures, from training health workers to securing government resources for reproductive health initiatives. An NPC staff member said, "The government is committed with elaborate laws, and it is beautiful on paper. So then it needs to provide resources!"

Respondents appeared to gauge implementation success as a function of the population's knowledge and practice of reproductive health issues and behaviors, especially contraceptive use. The consensus among respondents was that although knowledge of reproductive health issues is widespread, contraceptive use is too low. An MOF respondent commented, "Massive awareness has been created, but it stops there. People are not practicing. This is the biggest challenge. Beyond introducing the practice, you must say what it is about and give information. We need to deepen knowledge, too." Most respondents were optimistic that increases in contraceptive use were imminent; some admitted, however, that they had been optimistic for some years now and that nothing had changed. A university respondent said, "If you asked me in 1970 where we are going, I would have said the CPR [contraceptive prevalence rate] would be in the 30s [30 percent] by now. Kenya is way ahead of us."

Making Decentralization Work

The government is progressing with its decentralization strategy; population agencies such as the NPC and MOH are nearing completion of their restructuring plans. The challenge now is to make sure that local-level leaders and administrators are aware of reproductive health issues and allocate adequate resources accordingly. An NPC staff member said, "The political part is easy—the geography of marking the districts, getting the district assembly people appointed and elected. But then add the bureaucratic side. How to do their duties is difficult." Respondents concurred that education efforts must be directed at local officials so that they see the importance of reproductive health problems in their areas. An MOF official stated, "We need a lot more education in the districts. If we succeed to educate them, they will generate a lot more resources for population." The NPC and MOH structures in particular need to be strengthened at

the regional and district levels to ensure the success of education efforts.

Ensuring Continued Participation of NGOs and the Private Sector

Historically, NGOs have been major partners in population and reproductive health policy formulation and program implementation in Ghana. They have filled in gaps in information and service delivery and have influenced policy formulation at all levels. The public sector needs to continue its successful collaboration with NGOs.

Appendix 1

Organizations Represented in the Interviews

Government Organizations	National Population Council Secretariat (various divisions); Ministry of Health (various departments); Ministry of Finance and Economic Planning; National Council on Women and Development; District Assembly, Dangbe West, Greater Accra Region
Nongovernmental Organizations	Planned Parenthood Association of Ghana (PPAG); Save the Children Fund
Donors	U. S. Agency for International Development (USAID); United Nations Population Fund (UNFPA)
Technical Assistance Organizations	POLICY Project; Association for Voluntary and Safe Contraception (AVSC); Population Communication Services (PCS); Ipas
Academic Institutions	Population Impact Project (PIP), University of Ghana; School of Public Health, University of Ghana
Private Sector	Ghana Social Marketing Foundation (GSMF); Ghana Registered Midwives Association (GRMA)
Service Providers	Rural midwife; District Health Management Team (DHMT)
Other	Member of Parliament; Private consultant

Appendix 2

Existence of Policies

Components of Reproductive Health Policy	Policy in Ghana
Family Planning	1969 *Ghana Population Policy* 1994 *National Population Policy* 1995 *Ghana Vision 2020* 1996 *National Reproductive Health Service Policy and Standards* 1996 *Adolescent Reproductive Health Policy* (draft)
Postabortion care	1996 *National Reproductive Health Service Policy and Standards*
Safe pregnancy	1994 *National Population Policy* 1996 *National Reproductive Health Service Policy and Standards*
RTIs	1996 *National Reproductive Health Service Policy and Standards* 1996 *Adolescent Reproductive Health Policy* (draft)
STDs	1992 Guidelines for AIDS Prevention and Control 1994 *National Population Policy* 1996 *National Reproductive Health Service Policy and Standards* 1996 *Adolescent Reproductive Health Policy* (draft) 1997 *Policy on AIDS* (draft) (education, research, and training only)
HIV/AIDS	1992 Guidelines for AIDS Prevention and Control 1994 *National Population Policy* 1995 *Ghana Vision 2020* 1996 *National Reproductive Health Service Policy and Standards* 1996 *Adolescent Reproductive Health Policy* (draft) 1997 *Policy on AIDS* (draft)
Adolescents	1996 *National Reproductive Health Service Policy and Standards* 1996 *Adolescent Reproductive Health Policy* (draft)
Nutrition	1994 *National Population Policy* 1995 *Ghana Vision 2020*
Cancers	1996 *National Reproductive Health Service Policy and Standards*
Infertility	1996 *National Reproductive Health Service Policy and Standards*
FGM	1994 FGM Law 1996 *National Reproductive Health Service Policy and Standards* 1996 *Adolescent Reproductive Health Policy* (draft)
Gender-based violence	1996 *Adolescent Reproductive Health Policy* (draft)#
Reproductive rights	1969 *Ghana Population Policy** 1994 *National Population Policy** 1996 *National Reproductive Health Service Policy and Standards*
Menopause	1996 *National Reproductive Health Service Policy and Standards*

Violence against adolescents and biases against the girl-child

* Reproductive rights for *couples*, not individuals

Appendix 3

Members of the National Population Council

1. Professor George Benneh, University of Ghana, Legon, Chair
2. Mamaga Amega Kofi Bra I, Queenmothers Association, Vice—Chair
3. Executive Director, NPC
4. National Council on Women and Development
5. National Association of Farmers and Fishermen
6. National Development Planning Commission
7. Ministry of Finance
8. Ministry of Health
9. Trade Union Congress
10. Ghana Statistical Service
11. Ghana Medical Association
12. National House of Chiefs
13. NGO
14. NGO (May Day Rural Project)
15. NGO (PPAG)
16. Government Appointee
17. Government Appointee
18. Government Appointee
19. Government Appointee (31st December Women's Movement)
20. Government Appointee (Catholic Secretariat)
21. Government Appointee (Public hospital physician)
22. Government Appointee (National Commission on Children)
23. Government Appointee

Appendix 4

Components of Reproductive Health and Locus of Implementation

Components of Reproductive Health	Locus of Implementation
Family Planning	National 1970
Postabortion Care	National; some training of and equipment for private and public midwives and physicians
Safe pregnancy	National
RTIs	National; but not all levels have been trained
STDs	National; but not all levels have been trained
HIV/AIDS	National; concentration on education
Adolescents	National; concentration on education
Nutrition	National
Cancers	Planned; presently teach breast self-examination
Infertility	National counseling; some private hospitals offer invitro fertilization
FGM	National
Gender-based violence	National; addressed by NCWD and other NGOs
Menopause	National counseling
Integration	National; service integration not complete; referral systems in place

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